MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, March 21, 2002
10:10 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Changes in private sector benefit packages: Implications for the Medicare benefit package
-- Marsha Gold, Mathematica Policy Research; David Glass

MR. HACKBARTH: ...Marsha, you're going to lead us through the discussion about...

DR. GOLD: David was going to introduce me, and Bob's going to stay up here because he's been a good raconteur on the reports that I've done, that I'm presenting.

* MR. GLASS: Marsha is now going to lead us through a discussion of the changes in the private sector benefit packages. She's going to talk about how they've evolved and what their current status is. We'll also compare it to the Medicare benefit package.

And then we'll ask the Commission to think about what are the implications of that for rethinking the Medicare benefit package. To what extent does it make sense to think of the employer group market as a model for the Medicare population, given what the last panel just said about how you have these different populations in Medicare.

Marsha, go ahead.

DR. GOLD: Thanks. I'm going to walk pretty fast through what was a pretty extensive analysis. The objectives were to review the historical trends in employment-based health benefits -- although I should emphasize this is for active workers -- and to compare the results against trends in Medicare benefits, and then to identify the implications for reforming the Medicare benefit package. Although, some of that discussion is probably going to be held over until tomorrow when you get a chance to have more time with that.

You have the executive summary of that report. You can get the full report, should anyone desire it, from the staff. I'm not going to go into a lot of the methods.

We tried to go back as far as we could to what employment-based benefits were like when Medicare was started. There's some anecdotal information there but '77, with the National Medical Expenditure Survey, was really the first documentation nationwide.

What that showed was that basically people had a single choice of health plan. It was an indemnity package that had basic benefits and some major medical benefits. There was limited preventive services. Pharmaceutical services were included. Drug coverage was part of major medical. We see, even back then, the disparity or the distinction between the coverage for mental health and the coverage for other conditions.

If you look over the 1980s, largely through the BLS surveys, what you see is the integration of basic and major medical benefits was occurring, which basically meant there was more cost-sharing on the first dollar side of it.

At the same time, there was greater protection on heavy expenses. That is, an annual limit on out-of-pocket spending. Even in '77 that was about half of the people with major medical, I think. It went up from there.

We started to see a growth in HMOs, though it was still limited. Utilization review got added to indemnity coverage. And you saw higher worker contributions to premiums, especially for family coverage.

In the 1990s what you saw is more plan choice, managed care options, and basically -- I have a slide I'll show you next -- but the PPO replaced the indemnity product. The worker's share of the premiums for coverage have remained relatively steady from the mid-1990s.

Cost-sharing appears to have declined, but that's a complicated topic and a lot of it is that there was the growth of managed care and cost-sharing is different within different forms of managed care. In the paper, there's some good information on how that varies.

I noticed that there was just today a Health Affairs web exclusive by Jamie Robinson on out-of-pocket costs. I think within individual products, cost-sharing has gone up. But cost-sharing, as a whole, hasn't gone up because of the shift to managed care products.

There remain annual limits on out-of-pocket expenses. Again, they've gotten more complex because they're dealt with differently in different products, and for in- and out-of-network benefits. Pre-tax spending accounts, that is to pay for the cost-sharing, are more common. But at least the data I saw, it seems like only a minority of workers participate in those.

This is from the Kaiser/HRET data that's been done on type of plan enrollment. What you can see, that yellow bar shows the growth in PPOs against red, which is the erosion of the indemnity benefit. That's both a reflection of offering, because indemnity is less likely to be offered, but just as much what people are selecting because there's more offerings than there are people enrolled in indemnity.

Additional trends in the '90s, we've seen some expansion in the SNF/home health/hospice benefits, although they are still limited. Long-term care coverage may be growing but it remains rare. Substance abuse benefits have improved, but both they and mental health benefits still lag general health benefits. Preventive coverage has expanded, though it's still more common in HMOs.

In terms of what the pharmacy benefit looks like

in the employment-based coverage, virtually all workers who have coverage do have pharmacy benefits. It's very rare that there's any yearly maximum, as there has been in some of the Medicare+Choice plans.

Tiered copayments are commonly used as a way to control costs. As of the most recent year, three-tiered copayments are now as common as two-tiered. So that you may have a generic, a preferred brand, and another brand, or there's various ways of structuring that. For the most part, the pharmacy benefit is integrated with medical coverage. It's not a separate stand-alone benefit.

In terms of looking to the future, and it's been challenge and it will be a challenge for you, is that costs are very cyclical. These are just the average health benefit costs for active workers, so they're the costs that the employer is paying.

What you can see is that in the late '80s, early '90s, those increased a lot. People did some things. They introduced managed care. Costs didn't go down a lot. Now they're going up again. And so what the question is is what's going to happen? I've just described where the benefits are or as today as you get in these data. And I think the Kaiser/HRET data are pretty current but it's still lagging, and so what the future is.

There's a number of emerging pressures and influences on that. Probably the dominant driver of all of this is the tension between what employers face in terms of growth and health care expenses, which relates to a lot of the changes in medical technology, site of care, all the things Bob talked about, and the need to -- you know, most businesses are in business not to do health care. They're in business to do something else. And so they need a labor force for that. They may be willing to absorb some costs of health care as a trade-off against not getting a good labor force.

So we've had changing economic conditions over the mid to late-1990s. It was a very strong economy. Aside from the fact that health care costs weren't rising that quickly, there also was not a lot of pressure to reduce health benefits because there was greater interest in getting labor force participation. The economy is a little softer, health care expenses are higher.

And so one of the questions is how are employers going to trade that off? They're obviously faced with some regulatory constraints and negotiated contracts in doing that.

I'm not a crystal ball thing and I think usually people are wrong more than right. But when I looked across the various consulting management reports and other things

and tried to give you a sense of what it looked like people were saying, the concern is that cost pressures were going to encourage change in health benefits. That is, ways of keeping costs down. But the labor force concerns will moderate it.

Most people expect increased cost-sharing on the patient side. That was the focus of the Robinson article, which I haven't read yet, that just came out. The data that I looked at it's not very detectable yet. I don't know when it will start showing up. There's probably people on this panel who are more expert in that.

Most of the people that were writing when I was looking at the things expected what I'd characterize as evolutionary, not revolutionary change. That is, they see changes at the margin rather than a total switch in how benefits are defined. From the revolutionary side, if you just looked at the defined contribution data, a few workers are in them today. And the surveys that are there show growing but still limited employer interest in those products. And the products themselves, you have to be very careful because they're very different and a lot of things go by the same name and they're very different and they're evolving.

There's more detail in the paper about that issue if you're interested in it.

A key focus in the paper, and there's about three page chart that tries to do it, is to compare Medicare to employer group products then and now and look at what's the same and what's different. What you can see if you summarize it is that there are similarities across both of those products. Both are medically focused with an emphasis on acute care. Neither is strong in prevention, although both have gotten better recently. Both have more limited coverage for mental health services than medical care.

And this last point is a point one could debate, but I think it's probably accurate, is that neither focuses heavily on care management, though there is some activity there.

In terms of the differences, there's no equivalent in employer group coverage to the current Part A/Part B split in Medicare. Medicare has more limited inpatient coverage with more first dollar cost sharing. There's no equivalent to that first day deductible in most employer plans.

Employers cover prescription drugs and Medicare generally does not. Employer group coverage provides greater protection against high expenses because of the annual limit.

I should indicate when I say this, though, that

some of the disparities are overstated because Medicare has more protection because of balance billing limits than private insurers do. Those out-of-pocket limits don't affect any balance billing. So in some ways, they may give a false sense of how much protection there is on the employer side.

Differences. The basic employer plan is a PPO and Medicare is still an indemnity plan. That means that utilization review and a limited network are very common for employers, not very common in Medicare. I think, this group particularly being a group that deals with payment, will appreciate that one of the ways of how to think about the Medicare indemnity product, given administrative pricing. To some extent, one could think about Medicare has getting the benefit of PPO price negotiations without out of network use. And if the pricing is better and there's less participation, you might end up with a de facto PPO.

But some of the reasons employers go into PPOs is to get price discounts and that may be less critical in Medicare because of the administered pricing issue.

Second, contributions are really hard to look at because of the A/B split and because on Part A you're essentially -- or at least I think when I look at my paycheck, that I'm paying for it each month when I get my paycheck. But if you look at just the Part B, the Part B contributions are at a par or higher than the contributions for single coverage in groups. That is both absolute dollars as a share of premiums, Medicare beneficiaries in Part B are paying at least as much as single people in employer groups.

Part A, there's no payment, but I don't know how to deal with that because of the payments into the trust fund. So I'm not quite sure how important it is to compare that premium contribution, but I'm not sure what rules to use.

The last point, which I think will come up a lot when you talk about the supplemental market, which I would encourage you to not ignore as you think about the benefit package, because of the role of the supplemental market, is that choices are much simpler for those with employment-based coverage than Medicare. That's mainly because of the choices that are involved in supplemental coverage, where you have to know whether you're in an employer group or not, and if there an HMO in your area or not? And are you eligible for Medicaid or not? That varies in each state.

Those get quite complicated and I think one of the risks, as one tries to figure out how to improve the Medicare benefit package or address limits in benefits through other areas with a limited budget constraint, is you

do make marginal changes in benefits but they have some pretty nasty effects in terms of the complexity of choice that it looks like to the beneficiaries as you go forward. So good intentions can lead to a lot of complexity.

DR. ROWE: Can I ask you to clarify something, Marsha? You said, on the last slide, Part B contributions are at a par or higher than contributions for single coverage in groups. Were you thinking about that in an absolute dollar or as a percent of the health care cost?

DR. GOLD: Both.

DR. ROWE: Because the health care costs are so much greater in this population.

DR. GOLD: It was both, but restricted for Medicare side to only the Part B. So I didn't take into account the Part A expenses. But both the absolute dollar on Part B and the share of the premium it is is higher.

I was surprised at that. I actually frankly thought it would be less. But again, because Part A is left out, I don't know quite what to make of that.

DR. ROWE: Thank you.

DR. GOLD: Just the last slide, to summarize, I think what you see is that Medicare and employment-based benefits share some similarities but Medicare benefits are generally more limited. And when I think you look over time, the disparities are growing. So the question that the Commission faces, not only today but tomorrow and over the next few months, is what to recommend; how best to address Medicare's current limitations; and especially what principles should apply to any efforts at modernization.

I have, in the paper and in the executive summary you have, a more extensive discussion of that. I'm not going into it here, because that's really the focus of your meeting tomorrow, but you might want to take a look at that before then if that's of interest.

I'll take questions.

MR. HACKBARTH: Marsha, I have a question about this one.

DR. GOLD: I was afraid somebody was going to ask me about that slide.

MR. HACKBARTH: It's probably not what you're fearing. Let me get your reaction to an observation, that there is a correspondence between this pattern of declining rates of growth in the early '90s -- very low rates of growth in the mid-1990s, and then now more recently an escalation -- with what's been happening in terms of the organization and delivery of care and how that works with health plans.

In the '90s there was a movement, not universal but some movement towards people being in systems that were

more structured, organized, some would stay restrictive, both for the enrollee and for the clinicians and providers participating in them. Now by popular demand we're moving more towards health plans and delivery systems that are focused on maximizing choice.

Question number one is do you agree with that as a general observation? Question number two would be maybe what this presages is the pendulum swinging back again towards more structured organized systems. That people are slowly perhaps but inevitably learning the connection between organization of delivery and the cost of care.

We may learn slowly but eventually we will learn.

DR. GOLD: Yes. I think I agree with that observation. I want to sort of caveat it. It's clear that, at least from the employer end, the shift to managed care -- I think at least in their minds and a lot of other people's minds when they've looked at it -- has resulted in some of the savings.

Some of that is overstated, I think, because the underwriting cycle probably meant that the increases before were higher and also some of that savings was because people underestimated how much things would cost, and so they come back up again. So there were some savings through managed care.

As you know, I've sort of looked at managed care a lot, and I think most people in the industry -- and certainly, I would think, from a policy perspective -- would agree that there are some fundamental issues of technology, of coverage, of what people should have which just moving from a fee-for-service system to a managed care system doesn't resolve. In fact, that was probably some of the biggest reasons there was a backlash, because people called it managed care but we didn't change the underlying infrastructure, nor did we deal with some of the ethical issues as to who should have what.

So those dilemmas remain whether you move to a managed care system or not. Now I don't know, one can say it's half empty or half full. I remember Rashi Fine teaching me in 1970, in my first health care course, do we have national health insurance first or do we get costs under control? I somehow sometimes think that everything stays the same and nothing changes.

I do think a key -- I mean in my mind at least, dealing with the issue of what is appropriate, what kind of care people should get, and also what we expect of the delivery system are the two fundamental things that will affect costs of care, regardless of who's paying for it and the fight over that. But what will happen with that, I'm not terribly sanguine. I sometimes feel like we won't deal

with those things, instead we'll just have cost-sharing, we'll go back to the '50s and we'll deal with out-of-pocket costs. But that has a tough effect on people who are sick.

MR. HACKBARTH: Just for the record, I agree with your point about this exaggerating the changes in trend because of the underwriting cycle.

MR. GLASS: It might also show the provider push-back. If most of those gains were because you were getting providers to accept discounted rates and now providers are not going to do that anymore, you see that pattern.

MR. HACKBARTH: Although I think that's a function, in part, of network size and how inclusive the networks are. Providers can push back a lot more if it's an all-inclusive network and if the plan is willing to restrict.

DR. GOLD: And also, in a backlash environment it makes it easier for them to push back because all the press has said how bad HMOs are.

MS. ROSENBLATT: I have quite a few points on what you said. I thought this was very well done. Let me just add to the discussion that just occurred.

I agree with you, although since I've had personal experience back in the '70s, there's a feeling to me of what's going on right now is sort of a back to the '70s.

But I do think, and this is my own opinion, not that of my employer, not that of any actuarial academy. But my own opinion is that the underwriting cycle caused a lot of that, and the underwriting cycle was masked for several years by the movement to managed care and the positive selection that the HMOs created through that movement to managed care.

And that by giving consumers the trade-off between limited networks and more open access through a PPO, for example, a lot of the savings that have been attributed to managed care were due to that positive selection and that the richer benefits were a cause of that because the richer benefits were necessary in that trade-off choice. So there are a lot of complicating factors there.

I think again, Glenn, your comment about the trade-off between benefits and networks, it all fits together.

DR. GOLD: That's helpful.

MS. ROSENBLATT: Was there any reason why you looked at group coverage as opposed to individual coverage? Because one of the things that I think a lot of people always say is the cost of group coverage is so masked to the individual because 80 percent of it is generally paid by the employer, that those benefits are very different than what you would see right now in the individual market where the

individual is bearing the full cost?

DR. GOLD: I looked at group coverage because I was asked to. I think I probably was asked to because people realize exactly what you said, and that the individual products are -- the coverage is so much less at so much more expense. And the idea was saying when Medicare started, people -- I'm not sure this is exactly true because I went back to try and find it. But it's common belief that Medicare was modeled after the employer-based plans, and certainly they are after some of the more common ones.

So the thought was let's look and see how it compares now to what it was then because that might be a precedent. And I think if my colleague, Debra Shallet, was here, she could talk more about some of the limitations in the individual market. But I think it's recognized there are a lot. I didn't look at it because I wasn't asked.

MS. ROSENBLATT: Maybe that's something we should consider. Because it is extremely different.

DR. GOLD: I think there's some good papers on that already.

MS. ROSENBLATT: You'll probably find there's more catastrophic coverage. It also gets to your parity question because there is no employer funding, so to speak.

DR. GOLD: The paper does go into the issue of just whether people have the coverage, if they are in an employer group. So there's some data on that there.

MS. ROSENBLATT: The other point I wanted to make is you've got that slide of what was covered in 1977, and you mentioned that outpatient prescription drugs were covered. You said it was part of major medical, and I'm not sure everybody understands that.

Coverage for outpatient prescription drugs in those days of indemnity plans put the prescription drug benefit under the deductible. The deductible in those days was typically $100. So if you were healthy and the only expense you had was a drug, and the cost of drugs those days, you very rarely got to have that as a benefit because your drug costs never hit the deductible.

And again, if you look at individual plans right now, there's a movement away from the copay and towards that type of deductible product.

DR. GOLD: I'm not sure I saw the movement of the deductible product, but I think that's otherwise right. The paper does provide information on the size of the deductible back then.

DR. REISCHAUER: I just have a footnote on that. I was groveling around for information on what fraction of prescription drugs were paid for by insurers around the mid-

1960s. It was only something like 5 percent, for exactly this reason. It wasn't that many didn't have "coverage" for prescription drugs but they never amounted to much. You collected them, you had to send them in, you lost the slip and all that.

MS. ROSENBLATT: One of the things you mentioned that I haven't done research on, but it just strikes me as being different in the industry. You said the pre-tax spending accounts were not very common. You're talking about FSAs, flexible spending accounts?

They're very common, from what I've seen.

DR. GOLD: What I was talking about, I think they're commonly offered by especially the larger employers, which is probably what you see. The take-up rates of employees isn't as high. I'm referring to Bureau of Labor Statistics data. It may be out of date.

Also, it's more common among the large employers, which is probably what you're thinking of more. The take-up rates and the amount are relatively low. It is higher for higher income people or people in higher jobs, so probably what you see is the higher share of that.

MS. ROSENBLATT: I also agree with the point that you made that the data is lagging what's happening. Because if you follow that curve where you saw three years of increases, you ended in 2000 if I remember correctly? 2001 and 2002 continued that curve and my expectation is 2003 would continue it.

So I think that I agree that it's going to be evolutionary not revolutionary. But the employers, from what I see the employers are definitely increasing copays, increasing deductibles, cost-sharing, looking for ways to do things with networks that will save costs, and putting more premium contribution on the employees. So there's a definite trend.

DR. GOLD: If I can just clarify, the Kaiser/HRET data was for 2001, but all the other data was earlier than that.

MS. ROSENBLATT: And there is 2002 data available, I think, because most of the large employers at least renew new on January 1st, 2002. So there ought to be some data available.

DR. ROWE: Let me just comment on that, Alice, from another point of view. We saw, I think, in our book of business contracting in January of this year, on average, about a 3.5 percent buy-down with respect to reductions in benefits on the part of employers in order to try to reduce their expenses with respect to the contracts.

DR. GOLD: Can I ask you just in what form that was translated to the employee, if you know? Is it mainly

cost, copays?

MS. ROSENBLATT: Buy-down would be benefits. Jack wouldn't see the effect of the contributions.

I have only three more points, bear with me. I also agree with your PPO point, that it's very similar to what happens with some of the Blue plans back in the '60s and '70s where the Blue plans were the only carrier out there that had negotiated discount arrangements with providers. In effect, they were very, very large PPOs. Therefore, many of the Blue plans did not need to have PPOs because their indemnity was similar to PPOs.

So I agree with your comment that Medicare could be moving in that direction, as well.

MR. HACKBARTH: We're going to start to charge copays for sequential comments, I guess, escalating copays.

[Laughter.]

MS. ROSENBLATT: I disagree with two. Choices are simpler with employment-based coverage in the Medicare. I think choices are pretty difficult with employment-based coverage, as well. I don't think it's fully understood. I mean if, in fact, people are not taking advantage of FSAs, some of the things that you said, there are some pretty complicated choices out there.

It's easier where the employer doesn't give choice. But where the employer is giving choice, it's tough.

DR. GOLD: I think the main issue I was concerned with there was the supplemental market, if you overlay that. I don't know that Medicare itself is more complicated than employment based coverage, but that whole overlay of different forms of supplemental coverage made things more complicated to the beneficiary because they have to figure out which of those they're eligible for. It may not be that different for someone who's eligible for group-based retirement coverage.

MS. ROSENBLATT: Absolutely, similar issue there.

My final point, I'm worried about the point Jack asked you about the Part B premium. I didn't quite follow it and I'm not sure that I'm there. So I might need to have a side discussion on that one.

DR. GOLD: There's more data in the report.

DR. REISCHAUER: Can I offer something? It's really quite simple. Premiums are 25 percent of Part B spending by law, average employers charge 10 percent --

DR. GOLD: It's about 18 percent, I think, for self.

MS. ROSENBLATT: Are we comparing Part B with total?

DR. GOLD: That's what I said. And I say, I'm not

sure that's appropriate, but that's what it is. I was trying to address whether the premium contribution was the same, but I'm not quite sure how to do that.

MS. ROSENBLATT: I'm done.

MR. FEEZOR: One thing good about letting Alice run on, she hit one of my points.

I do have to generally say that, first off, I do think we need to work -- and I know the Foster Higgins now is out and the 2001 figure I think was like 11.2 or something like that. And I think early indicators will show that 2002 are between 12 and 13 percent. So we are seeing that curve go back up.

DR. GOLD: I can update that chart.

MR. FEEZOR: That gets to Alice's point. I guess we almost ought to fall prey to what I call the actuarial concern. Given the cost trends, and I would suggest that since I'm one of the first in the barrel in 2002 and I hope I'm atypical, but we will be looking at some trends that begin to approximate what the late '80s, early '90s were, every indication. I see Alice sort of nodding. Let's hope it's a West Coast phenomenon, but I'm very worried about that. I'm talking north of 15.

And there is the inevitable response, there's a lag time between employers sort of grasping at, we'll take it the first year, and I think we are on the cusp of a significant erosion -- Jack pointed to it in his comment just a second ago -- that will, in fact, begin to show up and accelerate. I think Marsha is absolutely right. Most of those changes, in looking at alternatives, whether it's smaller networks, going back to tiered products not just in pharmaceutical but tiered networks, to even less choice which we've seen over the last couple of years in private coverage, that those are going to be accelerating.

And I think our report needs to try to do the actual route of maybe putting the greatest weight on the last year or two's evidence, in terms of as we start to look forward as opposed to saying well, in a 10 year picture it really isn't great movement. So let's use the most recent look back.

Particularly one area that I do think was not captured because it's hard to capture, is that a fundamental theme of employment-based coverages that they're not executing too well on is greater enrollee engagement, not just on the cost side, but in terms of their decisionmaking, their responsibility for their own care coordination.

Whether or not that is something that could or should be carried through to our aging population is a question, but I think that is a trend that certainly the new plans like Definity, that are enhanced by information

technologies and other profiling opportunities do come into play that will be more evidenced in the private area.

DR. GOLD: There's additional detail on that in the paper.

MS. NEWPORT: Thanks for coming today. It's very helpful.

I was very anxious to hear what Allen had to say, from his perspective as an employer purchaser group on trend, so I won't go into that.

I would caution maybe as we look forward here is looking at the nomenclature issue, understanding market share between PPO, HMO, indemnity, point-of-service, for example, in the complexity in choice that beneficiaries have.

Our survey data shows that benes that are in the classic HMO but think they're in a PPO have a higher satisfaction rate than those that are in a PPO. And I think that there's a real issue here. I was struck by -- can you see this, my staff does this to me all the time.

This bar graph, in terms of the market share and the movement towards freeing up choice but having members really understand what is happening in terms of delivery of care.

The other thing I think we need to bring out a little more on the employer's side is the effect of the tax benefit to providing this coverage, and acknowledge it in terms of lining up what share of the costs is there.

Again, I would echo what Alice and Allen have said about the trend data is looking more closely at the most recent tend, although I know there's some limitations in that, and really understanding what's happening. I think that much of the rhetoric around managed care, in the classic sense, we don't find we have a classic managed care product anymore, in terms of our response to the marketplace.

So I think that I would just like to urge, as we look forward on this, that we are very careful about how we categorize and define these products because it is evolutionary, which is a point Marsha brought out. But I do appreciate your thoughtful presentation.

DR. NEWHOUSE: I just have a couple rather picky points. If I were a reviewer, this would be in the specific comments, rather than the general comments.

The first is there's actually a couple of earlier national household surveys than the National Medical Care Expenditure Survey that were done out of the University of Chicago by Odin Anderson and Ron Anderson.

DR. GOLD: Did they have insurance coverage on there with the benefit package? A lot of times, Joe, those

household surveys that are done -- and NHIST was done I think before then -- but you have to survey employers to get at what the benefit package was.

DR. NEWHOUSE: That's right, but they do have what percentage of various kinds of bills were paid. The point I was going to make is that actually if you go back, it's not only drugs where there's a very low coverage. It's also office visits. Medicare in the '60s is actually in advance of much of private coverage by covering office visits.

My recollection is actually different from Bob's and yours. I don't think drugs are generally a covered benefit in the policies in the '60s. I think it's not just that they didn't satisfy the deductible.

DR. GOLD: Major medical was growing, so it may be that major medical wasn't bigger in the '60s. It was growing towards the '70s, which may be why it shows up in NMES but not in --

DR. NEWHOUSE: One indicator of that is just, as I recall -- I mean, I have some data from back then about the proportion of drug spending that was covered by insurance. As I recall, it's down in the fairly low single digits. Now there's enough people with chronic disease that are going to get above the $100 deductible to push it higher than that, if it's generally covered.

The other quibble I have is I'm not sure I'm comfortable with saying both Medicare and managed care have more limited mental health benefits than medical. It's clearly right for traditional Medicare, just on the copay side.

In a world of managed care and utilization review, I'm not sure how you would know it in private insurance.

DR. GOLD: Actually, I used to track that, as you know, back when I was at GHAA. You're right, it's hard to interpret what's equal, but there's more likely to be a visit limit or a day limit on the mental health benefit which doesn't exist on the other side.

DR. NEWHOUSE: I understand.

DR. GOLD: Now you may talk about appropriateness or all the rest but --

DR. NEWHOUSE: What do you mean it doesn't exist on the other side?

DR. GOLD: There's no general visit limit or there's no general hospital day limit, but there is a limit on mental health visits.

DR. NEWHOUSE: I understand that, but then I at, as I say, in a world of utilization review, it's not clear that that's the right test for assessing equal benefits.

DR. GOLD: I'm not sure it's the right test, but I think we may disagree on the conclusion.

DR. NEWHOUSE: If I have a world of unlimited benefits but I say gee, you don't really need care from XYZ, and therefore I'm not going to pay for it on the medical side, and I say you don't need this care on the mental health side either, I'm not sure, as I say, how to say that one is more equal than another.

If I'm a passive payer of whatever, bills come in, as in traditional Medicare and I pay more for the medical side than the mental health side, then the answer is clear.

DR. GOLD: I think that if you look at the structures that are in place, there are a lot more hoops to jump through on medical necessity for mental health and substance abuse than there are in general medical care. And so, it would seem to me that that makes the benefit more constrained on the mental health/substance abuse side because of the existence of more hoops in addition to -- you just don't have that same level of review on the medical side.

DR. NEWHOUSE: I agree with you about the benefit limits, but we'll leave it at that.

MR. MULLER: In the charts we received before the meeting showed the considerable drop in retiree coverage over the period of years. I would assume that these charts that Allen and Alice were talking about with the considerable rise in premiums for employers, that that drop would probably even accelerate as the population ages into 65?

DR. GOLD: No, I don't think so. If I can understand what you're saying, I think these are on active workers and their cost per covered individual. So I don't think --

MR. MULLER: But the ones that age up from age 64 into Medicare, I would assume that one of the things that employers do is even less likely to cover them.

DR. GOLD: In terms of the employer's total bill, if they're covering less retirees and they have more people aging into retirees, their total bill will go down. For the active workers, they'd still be facing some of the same cost pressures.

MR. MULLER: I'm talking about the ones that age into retirement, because when I tie that together with what's happening at the state level right now with a very precipitous drop in state revenues, and looking at those charts we have -- I don't have them memorized -- but something like 30 percent of the people have that retiree coverage. I think the Medicaid was a little less than 30.

You can see some considerable pressure, but states act much faster than Medicare does to drop things, so you can see some real dropping of coverage by the Medicaid

programs and the retiree programs, therefore putting Medicare more into a spot of --

DR. GOLD: That wasn't the focus of what I looked at, but I think it's a major policy that probably is relevant to your session after lunch because you're looking at the supplemental market. In fact, a lot of the sectors of that supplemental market are diminishing in their availability. There's less employer-based coverage. The benefit for the M+C plans is less extensive than it was. The price is going up on Medigap. I'm not sure what the Medicaid trends are.

So that is an issue. I think one of the big issues that the Commission faces is sort of what is Medicare's role? To what extent should Medicare be providing all of it? To what extent should there be a supplemental market? And will there be a supplemental market? So that factors in. But that's a real policy issue, as opposed to an empirical thing.

MR. HACKBARTH: I think the copay is now, I think, $35.

[Laughter.]

MS. ROSENBLATT: Talking about copays, Joe made a point about prescription drugs and I think that prescription drugs will receive a lot of attention it's very important that we do an accurate job of what the historical issue of prescription drugs is. I mentioned that my memory of the '70s, being an actuary in this business in the '70s unfortunately, I'm ashamed to admit, is that there was coverage through the major medical plan. I worked for a commercial carrier at the time.

What I don't know is there were Blue plans in the '70s, that some had a base and then a commercial carrier would come in with the major med. Other Blue plans had base plus major med coverage. I'm much less familiar with that. I don't know what those plans were in the '70s.

DR. GOLD: I didn't see that literature but, based on this discussion, I think I need to go back and certainly make the point about the major medical and look at some of those spending things. And if there are any other data that would shed any light on that, I'll incorporate that into the report. I agree.

DR. NEWHOUSE: But the right date for this comparison is the '60s.

DR. GOLD: If you can get it. Yes, I agree, if I can get it.

DR. NEWHOUSE: Drug coverage starts to come in in the '70s.

MR. FEEZOR: Just a quick comment, Ralph, on yours. There are two retiree populations you have to worry

about, the pre-65 and the over-65, and what an employer may or may not choose to do in either of those sectors is important. Clearly, the retirement issue was driven on the private sector in '92 -- when was FASB 106? '92.

The interesting thing, on the public sector side, a FASB equivalent which basically said you've got to put on your books somehow the expected cost of your retiree, is about to happen for the public sector. The initial exposure is this summer, June I think, at precisely a time when most of those coffers are, in fact, depleted. It will be interesting to see what that does also, in terms of state bonds, local bonds, and so forth.

It will be interesting to see if there is a similar acceleration of withdrawal by public employers. Probably not, we tend to be less resistant.

The one other thing, Marsha I don't recall it in the paper but it may be in the fuller edition, one of the greater enrollee engagement issues that I think private payers are trying to begin to push in a bit is removing the insulation to the pricing or increasing price transparency, I guess, is the current movement. Like Definity, the health market models are built on that. It will be interesting to see whether that persists.

DR. GOLD: I didn't see any of that. Part of that was what I did in conjunction with the Commission staff is not go through as much of the anecdotal literature and I was relying mainly on the national surveys and what they're tracking. I didn't happen to see that in any of the ones that I looked at. But it wouldn't surprise me that that was happening.

MR. HACKBARTH: I've been sitting here thinking about the comments that Alice and Allen made earlier about likely cost trends for employers in the immediate future. I'm getting depressed right before lunch.

One interpretation of all of this is that the apparent decline in the rate of growth in the '90s was not real, it was an artifact of underwriting cycles and selection and the stock market. You name it, a whole lot of things. And we really have learned very little about how to control costs and the evidence of that is about to hit us in the face with rapidly escalating costs for employers.

Medicare is a little bit different by virtue of its purchasing power. But in terms of controlling the volume of services, no different and probably even worse than the employer side.

If all of that is true, that has daunting implications for any discussion of adding additional benefits to the Medicare program, particularly in the context of the major imbalances that exist just because of

demographics. So I'm depressed.

DR. REISCHAUER: I'll try and bring you back from the depths of despair.

First of all, this period in the 1990s was one in which we squeezed a great deal out of providers. I mean sure, there was an underwriting cycle. Sure, there were shifts of people from one form of delivery to another.

But look at hospitals now. Look at physicians' relative incomes compared to investment bankers. Go down the list. And a lot of it was real and it's here to stay forever. Once you lower the level, it's here forever.

The second point that I think we all should be aware of is the projections for Medicare's costs that CBO and OMB have released for the next 10 years are the lowest growth in per capita benefit expenditures in the program's history.

Now some of that is due to the SGR.

MR. HACKBARTH: We know how good they are at estimating --

DR. REISCHAUER: You can even add in our excessive exuberance with respect to benefits and you would still get a lower -- some of it is because there isn't a drug benefit and drugs are what's driving a lot of the costs. But just to go to your point, which is how can we be sitting here talking about an expanded benefit package? I would say we're talking about it at a time when the projections are for the slowest growth in Medicare spending in the history of the program.

So cheer up.

[Laughter.]

DR. ROWE: Let me suggest a solution for you that's really going to drive you crazy.

If you're concerned about the numbers that you've been hearing here about the inflation rates in the health plans for Medicare costs, all of which are conservative, then you should remind yourself of the reciprocity between Medicare payments and commercial HMO payments, and increase Medicare expenditures in order to help drive down the medical trend in the health plans.

[Laughter.]

MR. HACKBARTH: I knew you would have a solution.

DR. WAKEFIELD: Give him a gold star.

DR. REISCHAUER: A statesman-like suggestion.